A Survey of Smoking and Quitting Patterns among Black Americans

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Abstract: A sample of adult Black policyholders of the nation's largest Black-owned life insurance company was surveyed in 1986 to add to limited data on smoking and quitting patterns among Black Americans, and to provide direction for cessation initiatives targeted to Black smokers. Forty per cent of 2,958 age-eligible policyholders for whom current addresses were available returned a completed questionnaire. Population estimates for smoking status agree closely with national estimates for Blacks age 21–60 years: 50 per cent never-smokers; 36 per cent current smokers; 14 per cent ex-smokers. Current and ex-smokers reported a modal low-rate/high nicotine menthol smoking pattern. Current smokers reported a mean of 3.8 serious quit attempts, a strong desire and intention to quit smoking, and limited past use of effective quit smoking treatments and self-help resources. Correlates of motivation to quit smoking were similar to those found among smokers in the general population, including smoking-related illnesses and medical advice to quit smoking, previous quit attempts, beliefs in smoking-related health harms/quitting benefits, and expected social support for quitting. Methodological limitations and implications for the design of needed Black-focused quit smoking initiatives are discussed. (*Am J Public Health* 1989; 79:176–181.)

Introduction

Promoting smoking cessation among Black Americans has been declared a public health priority.[1] Blacks, who account for 12 per cent of the US population, constitute the nation's largest minority group and have the highest smoking rate: 34.8 per cent of all Black Americans smoke compared to 29.7 per cent of non-Hispanic White and 25.7 per cent of Hispanic adults.[2] Among Black Americans, as for the US population as a whole, smoking rates are highest, and quit rates are lowest, within lower income and blue-collar subgroups.[3,4] Blacks also suffer the nation's highest rates of mortality and morbidity from smoking-related cardiovascular diseases and cancer—including coronary heart disease and lung cancer.[4–6] Moreover, smoking compounds other serious health risks within the US Black population, including a disproportionate incidence of infant mortality and low birthweight, hypertension, and diabetes.[6]

To date, relatively little research has been done to clarify smoking and quitting patterns and determinants among Black Americans, or to test quit smoking treatments in Black populations.[3,7,8] This paper presents results of a survey on the smoking and quitting patterns of lower and lower-middle income Black Americans. The survey was conducted to aid in the design of needed Black-focused quit smoking initiatives and to prepare for a smoking cessation intervention trial among policyholders of the North Carolina Mutual Life Insurance Company, the nation's largest Black-owned life insurance company.

Methods

Study Population

The target population for the survey consisted of North Carolina Mutual (NCM) Life Insurance Company policyholders aged 21–60 with active individual life insurance policies as of December 1985 and residing in 12 Southern, Mid-Atlantic, and Midwestern states and the District of Columbia where the company maintains active sales offices. All individual policyholders are Black and from predominantly low and lower-middle income groups. A stratified simple random sample for 4,000 NCM policyholders aged 20–61 was drawn from an unduplicated computer file of approximately 178,000 holders of individual life insurance policies in 37 geographic sales districts. To improve the statistical quality of survey estimates, selection of the sample was stratified by sex, age, and whether or not the policyholder had an industrial-type policy. Industrial policies (69 per cent of policyholders) have weekly or monthly agent collection of premium payments ("home service") and face values mostly under $1,000; ordinary policies are of either "home service" or mailed premium types and have face values of at least $1,000. Males were slightly oversampled to achieve a more nearly sex-balanced sample than the original policyholder sampling frame (57 per cent female).

Data Collection

The survey was conducted from April-September 1986. A variety of organizational factors and research objectives dictated the design of data collection procedures. At the time of the survey, the NCM home office did not maintain current addresses or telephone numbers for industrial policies. Its approximately 500 field agents, who see most policyholders on a regular basis, were regarded as the key to obtaining access to and cooperation of policyholders. Furthermore, since agents were to play a major role in a smoking cessation trial to follow this survey, involving them in data collection was essential to building a collaborative research relationship and assessing their research capabilities.

Agents were asked to:

- supply up-to-date mailing addresses and telephone numbers for all of their policyholders selected into the sample;
- notify subjects about the survey before mailing the survey questionnaires or deliver them in person;
- make a follow-up call or visit several days later to encourage cooperation and answer questions; and
- visit nonrespondents in person to provide further encouragement or assistance if needed.

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District-based group training sessions instructed agents in how to introduce the survey and encourage participation, and included both videotaped modeling of agent contacts and printed guidelines emphasizing confidentiality of responses. To minimize policyholder concerns about confidentiality, a cover letter attached to the survey explained the purpose of the study with assurances that participants would be identified only by code number, that completed surveys would be delivered in a sealed envelope to the research team at the University of North Carolina, and that individual results would neither be reported to NCM nor ever affect insurance rates or coverage. Cooperation was encouraged through modest lottery-style financial incentives for agents and policyholders, with primary reliance for agent compliance on the company's management structure. For reasons of policyholder and agent relations, NCM management discouraged direct contact with nonrespondents.

The "Smoking and Health Survey" requested sociodemographic information from all respondents (one page) and included separate additional sections for smokers (four pages) and ex-smokers (three pages).* Current smokers were asked about smoking rate, brand (brand name and Uniform Product Code number), nicotine dependence,[10] past attempts to quit or cut down, current desire to quit, beliefs about smoking health harms and quitting benefits, presence of smoking-related illnesses, and interest in self-help materials. Ex-smokers were asked about past smoking and quitting history and reasons for quitting. Standard smoking history items from the National Cancer Institute's self-help smoking cessation trials were used whenever possible.[11] The questionnaire was carefully pilot-tested for readability and ease of completion.

Results

Agents provided usable mailing addresses for 2,958 sample policyholders and reported an additional 249 as having lapsed policies. Withdrawing these 249 inactive policyholders, 107 potential subjects in a district selected for pretesting and 25 served by district offices no longer active yielded a potential sample of 3,619 subjects. Completed surveys were received from 1,237. Eliminating 74 respondents (6 per cent) ineligible on the basis of age left 1,163 eligible respondents. Counting as nonrespondents both those for whom agents did not supply an address and those who failed to return a completed questionnaire yields a 32 per cent response rate (1,163/3,619). Restricting the denominator to policyholders for whom agents supplied mailing addresses and correcting for estimated age-eligibility yields a 40 per cent participation rate (1,163/2,884).

Response rates for the 35 study sales districts ranged from 7 per cent to 62 per cent (median 38 per cent). Although there were regional patterns (generally higher rates in the South [15–62 per cent] and lower rates in the Midwest [10–51 per cent] and Mid-Atlantic [7–47 per cent]), there were marked differences within the same state or even the same city. Apparently valid addresses were obtained for 80 per cent or more of subjects in 25 (71 per cent) of the districts; seven districts provided addresses for only 45–69 per cent of subjects. Differences in district response rates appeared to be due to differences in access to policyholder populations and in agent and management enthusiasm for the survey. No relationships between response rates (as a percentage of the sample or as a percentage of apparently valid addresses) and prevalence of smokers, ex-smokers, and never-smokers were apparent in scatter plots.

Characteristics of respondents were compared with those of the total eligible sample in order to identify any systematic nonresponse patterns. Among the 16 sampling strata formed by sex, age, and type of policyholder, response rates varied from 22 per cent to 43 per cent. Response rates were 26 per cent (about 10 percentage points) lower for industrial policyholders, due to the unavailability of 26 per cent of their addresses. Rates for males were 11 per cent (4 percentage points) lower than for females, in both industrial and ordinary categories. Industrial policyholders, males, and industrial male policyholders age 40 years and younger were slightly underrepresented in the (unweighted) respondent sample (63 per cent vs 69 per cent, 46 per cent vs 49 per cent, 15 per cent vs 20 per cent, respectively, for respondents vs eligible sample).

To help compensate for nonresponse bias and to correct for the disproportion resulting from intentional oversampling of males, all estimates presented in this paper were weighted to the age, sex, and policy type distribution of the policyholder population. This was accomplished by means of a standard adjustment whereby, in effect, the mean of similar respondents was used as a proxy for each nonrespondent.[12] Estimates and variances were calculated using a computer program designed to properly account for the complexity of the sampling design.[13]

Smoking Status and Sociodemographic Data

Based on data from the 1,163 respondents, it was estimated that 50 per cent of NCM's policyholders were never-smokers, 36 per cent were current smokers, and 14 per cent were ex-smokers (see Table 1). The majority of policyholders were women, with a mean age of 39 years. Fewer than half were married. Most had a high school education or less, and most were employed full-time. Respondents reported a mean of 2.5 ambulatory medical visits in the past year, and 84 per cent described their health as "good" or "excellent."

Two-sample t-tests (two-tailed) and chi-squares showed expected relationships of smoking status to age, sex, marital status, education, employment and health.** Never smokers were predominantly women. Ex-smokers were older than current or never smokers. Fewer current smokers than ex-smokers or never smokers were married, employed full-time, or in excellent/good health. Both current smokers and ex-smokers were less likely to have completed high school than never smokers. One-third of current smokers, but half of ex-smokers, reported above normal weight for height and sex, and the mean Quetelet (weight/height) index was significantly higher for ex-smokers than for current smokers.[14]

Current Smokers' Smoking and Quitting Patterns

Current smokers began smoking at a mean of 17.5 years and had smoked for a mean of 19.4 years (Table 2). They were predominantly low-rate smokers, reporting an average of 14

*A detailed report of data collection and agent training methods and a copy of the survey instrument can be obtained from Mary Anne Salmon, PhD, Health Services Research Center, University of North Carolina, Chapel Hill, NC 27599-7490.

**More detailed documentation of sampling, weighting, estimation and analysis procedures can be obtained from William Kalsbeek, PhD, Department of Biostatistics, School of Public Health, University of North Carolina, Chapel Hill, NC 27599.

TABLE 1—Sociodemographic Characteristics of Individual North Carolina Mutual Policyholders by Smoking Status, 1986

Characteristics	Current Smokers (N = 399)	Ex-Smokers (N = 175)	Never Smokers (N = 589)	Total (N = 1163)
% Smoking Status	35.8 (1.7)	14.2 (1.2)	49.9 (1.7)	100.0
Mean age	37.2 (0.6)	45.1 (1.0)	38.5 (0.5)	39.0 (0.3)
% Female	49.5 (2.7)	47.4 (4.2)	69.8 (1.9)	59.3 (0.6)
Education				
% < High School	32.8 (2.8)	33.8 (4.1)	20.1 (1.8)	26.5 (1.5)
% High School	40.7 (3.1)	30.5 (4.3)	36.4 (2.3)	37.1 (1.7)
% > High School	26.5 (2.7)	35.7 (4.3)	43.5 (2.4)	36.4 (1.7)
Employment				
% Employed Full-time	49.8 (3.1)	69.4 (4.0)	65.9 (2.3)	60.6 (1.7)
% Married	27.8 (2.6)	52.0 (4.5)	43.2 (2.4)	38.9 (1.6)
Health Status				
% Excellent/Good	77.5 (2.6)	84.5 (3.7)	88.7 (1.6)	84.2 (1.3)
% Fair/Poor	22.5 (2.6)	15.5 (3.7)	11.3 (1.6)	15.8 (1.3)
Mean medical visits past year	2.4 (0.2)	3.0 (0.3)	2.4 (0.3)	2.5 (1.7)
Relative weight of smokers and ex-smokers				
% Normal or Low	66.7 (2.8)	49.0 (4.5)		
% Moderate Overweight	10.3 (1.8)	13.4 (2.8)		
% Severe Overweight	23.1 (2.6)	37.6 (4.4)		
Mean Quetelet Index	29.5 (0.5)	32.1 (1.1)		

Estimates are weighted to compensate for stratification and nonresponse. Standard errors are given in parentheses. No variable missing in ≥10 per cent of cases.

cigarettes a day. Fifty-two per cent smoked 10 or fewer cigarettes a day, and only 12 per cent smoked 21 or more cigarettes a day. However, most smoked high nicotine brands and most smoked within 30 minutes after waking, a crude index of high nicotine dependency.[10] Almost three-fourths smoked menthol brands; three menthol brands that dominate among Black smokers[15] (Kool, Newport, and Salem) accounted for 55 per cent of brands reported. Only 11 per cent of current smokers used tobacco products other than cigarettes.

Smokers in this population were estimated to have a mean of 3.8 lifetime quit attempts, relying mainly on self-change strategies and will power. Almost 80 per cent had tried once or more to quit, but fewer than 5 per cent had ever tried a formal group or individual treatment. Likewise, more had tried ineffective drugstore aids (14 per cent) than either self-quitting guides (9 per cent) or nicotine gum (7 per cent).

About nine in 10 current smokers had cut down their smoking in one or more ways during the past year. Cutting down on the number of cigarettes smoked and cutting down on smoking around nonsmokers were more common than either inhaling less of each cigarette or switching to lower nicotine brands.

Approximately one-fourth of current smokers had suffered from a smoking-related chronic illness in the past year (hypertension, heart disease, diabetes, bronchitis, emphysema, asthma and/or lung cancer), and over one-third had received personal medical advice to quit in the past year. Smokers generally expressed a moderately strong desire to quit smoking and strong beliefs in smoking health harms and quitting benefits, but they expected only moderate social support for their quitting efforts. Two-thirds were "seriously thinking about quitting smoking in the next year," placing them in the "contemplation stage" as defined by Prochaska and DiClemente.[16] Nine in 10 current smokers were interested in receiving a free self-quitting guide from NCM; 64 per cent were "very" interested.

To identify correlates of strong quitting motivation, the 47 per cent of current smokers with maximum "desire to quit" ratings on an 11-point scale were compared with the remaining 53 per cent on sociodemographic and smoking history variables. As Table 3 shows, the following variables were significantly associated with a strong desire to quit: female gender; lower nicotine cigarette brand; greater number of cut down strategies and previous quit attempts and methods; smoking-related illness or medical advice to quit smoking in the past year; stronger beliefs in smoking health harms and quitting benefits; and greater social support expected for quitting.

Ex-Smokers' Smoking and Quitting Patterns

Ex-smokers and current smokers were similar in regard to mean age of smoking onset (18 years) and mean smoking history (17.5 years) (see Table 2). Ex-smokers were older than current smokers and had been off cigarettes for an average of 10 years; only 9 per cent presently used other tobacco products. Like current smokers, ex-smokers had a relatively low daily smoking rate before quitting (15.5 cigarettes/day). Fewer ex-smokers than current smokers had routinely smoked within 30 minutes after waking.

As shown in Table 4, ex-smokers cited health concerns as foremost reasons for quitting: the desire to overcome present smoking-related symptoms was most often noted, followed by the desire to avoid future illness. Self-mastery motivation and quitting to set a better example for children or others were the next most common reasons. A variety of other motivations—economic, religious, cosmetic, social—were also endorsed.

We also asked ex-smokers to recall the quitting and cut down methods they tried (Table 2). Fewer ex-smokers than current smokers reported cut-down strategies: this difference was most pronounced for "cutting down around others who did not smoke," likely reflecting the major shift over the past decade in smoking norms and in knowledge and attitudes about second-hand smoke. Comparably small proportions of ex-smokers and current smokers had used formal treatments.

TABLE 2—Smoking and Quitting History for Current and Ex-Smokers

Variables	Current Smokers (N = 399)	Ex-Smokers (N = 175)
Mean age started smoking	17.5 (0.3)	18.1 (0.3)
Mean age quit (ex-smokers only)		35.5 (0.8)
Mean years quit (ex-smokers only)		9.5 (0.8)
Mean years smoked	19.4 (0.6)	17.5 (1.1)
Mean cigarettes per day	13.9 (0.6)	15.5 (1.1)
% smoking		
≤10 cigarettes/day	51.6 (3.1)	50.9 (4.5)
11–20 cigarettes/day	36.6 (3.0)	30.2 (4.0)
21–30 cigarettes/day	6.9 (1.8)	10.7 (1.5)
31+ cigarettes/day	4.9 (1.5)	8.2 (2.2)
% Smoke <30 minutes after waking	63.8 (2.9)	39.4 (4.2)
Mean mgs nicotine per cigarette	0.98 (.02)	
% High nicotine brand (>1.0 mg)	63.1 (3.1)	
% Medium nicotine brand (.7–1.0 mg)	28.3 (2.5)	
% Low nicotine brand (<.7 mg)	8.6 (1.8)	
% Smoking menthol brands (smokers only)	73.3 (2.6)	
% Other tobacco past month:		
Daily	1.2 (0.5)	3.6 (1.8)
Sometimes	9.8 (1.7)	5.3 (0.6)
Never	89.0 (1.8)	91.1 (2.4)
Mean lifetime quit attempts (smokers only)	3.8 (0.2)	
% ≥1 lifetime quit attempt (smokers only)	79.3 (2.5)	
Mean ways cut down (past year or prequit)	2.0 (0.1)	1.4 (0.1)
% cut number of cigarettes	60.8 (2.9)	50.4 (4.4)
% switched to lower nicotine	26.7 (2.6)	16.2 (3.3)
% cut down around others	62.1 (2.9)	39.6 (4.3)
% inhaled less/less of each cig.	52.6 (3.0)	37.7 (4.2)
Mean quitting methods tried (past year or prequit)	1.3 (0.1)	1.5 (0.1)
% Any formal treatment	4.1 (1.3)	2.7 (1.3)
group	1.1 (0.6)	0.4 (0.4)
one-to-one	3.3 (1.2)	2.8 (1.3)
% Books/guides	9.2 (1.8)	3.2 (1.4)
% Nicorette	7.3 (1.5)	1.2 (0.9)
% Any drugstore aid	14.2 (2.1)	3.3 (1.3)
filters	12.3 (2.1)	2.4 (1.1)
lozenges	5.9 (1.5)	1.5 (0.7)
% Prayer or meditation	19.0 (2.4)	21.7 (3.4)
% Will power	71.5 (2.8)	89.3 (3.4)
% With smoking-related illness past year	25.4 (2.4)	
% With medical advice to quit past year	35.0 (2.9)	
Mean belief smoking harms health (Scale 0–10)	8.5 (0.2)	
Mean belief quitting improves health (Scale 0–10)	8.5 (0.2)	
Mean desire to quit (Scale 0–10)	7.2 (0.2)	
Mean expected social support for quitting (Scale 0–10)	6.0 (0.3)	
% Seriously thinking of quitting in next year	67.6 (2.9)	
% Interested in free guide from NCM:		
Very interested	64.1 (3.0)	
Somewhat interested	26.4 (2.7)	
Not interested	9.6 (1.8)	

Estimates are weighted to compensate for stratification and nonresponse. No variable missing in ≥10 per cent of cases, except cigarette brand information, missing in 30 per cent of cases. Standard errors are given in parentheses.

Fewer ex-smokers than current smokers reported trying quit smoking books or guides, drugstore aids, or nicotine gum (not available in the US until 1984). More ex-smokers than current smokers reported relying on will power to succeed.

Discussion

The low response rate is obviously troublesome, but the final respondent sample appears reasonably representative of the eligible sample, and survey data were weighted to help compensate for the slight underrepresentation of industrial policyholders, males, and younger male industrial policyholders. Such weighting would not correct for the possibility that policyholders with a greater interest in smoking as a health issue (and/or whose agents were more vigorous in obtaining addresses and encouraging participation) are overrepresented in our respondent sample. Likewise, despite the strong emphasis on confidentiality of results, respondents may have attempted to present their behavior and intentions in a favorable light, particularly given the survey's identification with their insurance company. These factors would serve to create a "best case" bias, limiting generalizability, although probably not greatly limiting the usefulness of the survey to inform the design of quit smoking materials and programs for smokers interested in quitting.

Findings from this study are not directly generalizable to

TABLE 3—Sociodemographic and Smoking History Correlates of Strong Desire to Quit Smoking among Current Smokers (N = 399)

Correlates	Want to Quit = 10 (Scale 0–10) N = 185	Want to Quit = 0–9 (Scale 0–10) N = 214
Sex (% female)	57.8 (3.7)	42.1 (3.6)
Mean mgs nicotine per cigarette	0.93 (0.3)	1.0 (0.2)
Mean ways cut down (past year or prequit)	2.3 (0.1)	1.9 (0.1)
% cut number of cigarettes	73.2 (3.7)	52.7 (4.2)
% cut down around others	71.6 (3.8)	56.7 (4.3)
Mean number of prior quit attempts	5.1 (0.3)	2.6 (0.3)
Mean quitting methods tried (past year or prequit)	1.5 (0.1)	1.1 (0.1)
% Nicorette®	10.6 (2.6)	4.4 (1.4)
% Prayer/meditation	27.3 (3.9)	11.9 (3.0)
% Will power	84.3 (3.3)	59.9 (4.2)
% With smoking-related illness past year	33.6 (4.0)	19.6 (3.0)
% With medical advice to quit past year	43.8 (4.3)	27.3 (3.8)
Mean belief smoking harms health (Scale 0–10)	9.4 (0.2)	7.7 (0.2)
Mean belief quitting improves health (Scale 0–10)	9.5 (0.1)	7.6 (0.2)
Mean expected support for quitting (Scale 0–10)	7.1 (0.3)	5.0 (0.4)
% Very interested in free guide from NCM	87.9 (3.1)	42.1 (4.2)

Estimates are weighted to compensate for stratification and nonresponse. Standard errors are given in parentheses. No variable missing in ≥10 per cent of cases, except mean mgs. nicotine per cigarette, missing in 30 per cent of cases.

TABLE 4—Reasons for Quitting Endorsed by Ex-Smokers (N = 175)

Reason for Quitting	% Endorsing
To feel better physically	77.3 (3.7)
To prevent future illness	63.4 (4.2)
To take more control over my life	53.5 (4.3)
To set example for children/others	42.7 (4.2)
Don't like smell/stains teeth	33.2 (4.2)
To please or help a loved one	29.7 (3.9)
To save money	28.2 (3.9)
So my children wouldn't breathe cigarette smoke	23.0 (3.6)
Because my religion is against it	19.3 (3.3)
Because my doctor told me to	17.3 (3.6)
Because of immediate health problems	17.1 (3.5)
Because my friends don't smoke	8.5 (2.9)
Because of pregnancy (women only)	7.7 (3.1)

Estimates are weighted to compensate for stratification and nonresponse. Standard errors are given in parentheses. No variable missing data for ≥10 per cent of cases.

the general population of Black Americans. Compared to US Black adults 21–60 years, the weighted NCM respondent sample had a slightly higher percentage of females (59 vs 55 per cent); was somewhat older (38 vs 34 per cent of males were older than 40 years, as were 48 vs 36 per cent of females); and had somewhat greater formal education (26.5 vs 29.5 per cent had not completed high school and 36 vs 30 per cent had post-secondary education). It is reassuring that despite the high nonresponse rate the smoking prevalence (36 per cent) and ex-smoking prevalence (14 per cent) estimated for the policyholder population agree fairly closely with the national data (40 per cent and 15 per cent, respectively), suggesting only a small nonresponse tendency among current and former smokers.

Since this paper focuses on smokers and ex-smokers, the comparison of our sample of policyholders to the US by smoking status is relevant. Among current smokers, policyholders had the same sex and age distributions and slightly higher educational levels as for US Blacks (33 vs 37 per cent had not completed high school; 26.5 vs 23.3 per cent had post-secondary education). Among ex-smokers, the proportion of females in NCM was three percentage points higher than for US Blacks, the proportion older than 40 years was substantially greater (67 vs 48 per cent) and the distribution of educational attainment more extreme (31 per cent of policyholders versus 41 per cent of US Blacks had completed high school but not post-secondary education).*** However, the sociodemographic correlates of smoking in this survey (i.e., lower educational level, unemployment, being male, and being unmarried, poorer health status) are similar to those previously identified both for Black Americans[2,3,8] and for the US population as a whole.[2–4] It appears that the higher smoking prevalence among Blacks can be partially accounted for by Black/ White differences in these and other smoking-related sociodemographic factors.[3]

Present findings of a modal low-rate/high nicotine menthol smoking pattern also agree closely with existing data for US Black smokers. Black smokers, both men and women, smoke fewer cigarettes per day than White smokers;[2,4,5,17] in the present study, an estimated 52 per cent of smokers smoked 10 or fewer cigarettes per day. Comparable 1985 HIS figures were approximately 50 per cent for Black men and women smokers, a figure about twice as high as for non-Hispanic White smokers.[2] The 1981 Health Interview Survey found that 65 per cent of Black smokers smoked brands with 1.1 mg or more nicotine (in contrast to only 35 per cent of White smokers), and that 67 per cent of Black smokers smoked menthol cigarettes (in contrast to only 26 per cent of White smokers).[7] The present survey indicated very similar patterns: 63 per cent of smokers smoked brands with 1.0 mg or more nicotine; 73 per cent smoked menthol brands. Likewise, a recent regional study of 457 Black smokers found that three menthol brands (Kool, Newport, and Salem) accounted for nearly 60 per cent of all brands reported.[15] In the present survey, these same three brands accounted for 55 per cent of the brands reported.

Present evidence for relatively high nicotine dependency among Black smokers suggests that low-rate smokers of high nicotine menthol cigarettes may achieve higher than assumed levels of nicotine intake. Menthol cigarettes tend to be higher than non-menthol in tar and nicotine content.[15]

Sociodemographic correlates of quitting motivation in this Black survey population proved similar to those among US smokers in general, including: beliefs in smoking health harms and quitting benefits; recent smoking-related illness; personal medical advice to quit smoking; past efforts to quit or cut down; and expected social support for quitting.[18–20] Likewise, the quitting motives reported by ex-smokers are similar to those for national samples, with health concerns and self-mastery motivation foremost.[18–20] Hence, we would expect Black smokers to benefit from health education messages which emphasize the health harms/benefits of smoking/quitting, note that Blacks are not immune to these effects,[5] and are conveyed using sources, channels and media demonstrated to reach Black audiences.[7]

Past survey data suggest that Black smokers may try to quit as often as White smokers, but may succeed less often.[4,21] Present findings show relatively high quitting motivation and awareness of smoking health harms, and fairly active use of cut-down and self-quitting strategies among the current smokers surveyed.

On the other hand, present results show relatively limited use of beneficial quitting programs and resources by current or ex-smokers. There are, to date, no published data on the extent to which Black and White US smokers may differ in utilization of quit smoking services and resources. However, since Black Americans have more limited access to health care, particularly preventive care,[6] their access to quitting services and resources may also be more limited. Smoking cessation treatment outcomes for Black and White smokers of the same general socioeconomic levels are similar.[22,23] Therefore, improving access to existing treatments through established organizations within the Black community (e.g., churches, fraternal organizations, employers) should prove helpful. However, at the same time, it may be helpful in some circumstances to tailor the content and format of Black-focused treatments for maximum appeal and efficacy. Present findings suggest that such tailoring might:

- challenge possible misconceptions about the safety of low-rate smoking[24];
- introduce nicotine fading strategies designed to help smokers of high nicotine brands prepare for quitting[25];
- include Black ex-smokers as "peer coping models" to help enhance quitting motivation and efficacy[26];
- emphasize practical suggestions for avoiding excessive weight gain after quitting; and
- incorporate only print materials which have been pretested for comprehension and readability if the target audience includes a high proportion of smokers with limited formal education.[27]

ACKNOWLEDGMENTS

The authors gratefully acknowledge invaluable contributions by the research staff at the Health Services Research Center and the North Carolina Mutual Life Insurance Company: Brenda Allen, Robin Graham, Karen Mosely, Charlotte Nelson, Kim Numan, Carol Porter, and Beverly Thompson. We are also grateful to Edward Clemons, Elijah Cobb, Michael Fiore, Joyce Holloway, Berton Kaplan, Bobbie Lubker, Norweeta Millburn, Malvin Moore, Kermit Nash, Tom Novotny, John Pierce, David Phoenix, Carlton Spaulding, George Stevens, Robert G. Robinson, Connia Watson, Jesse Wiggins and the sales agents, sales managers and district managers of the North Carolina Mutual Life Insurance Company. This research was conducted at the Health Services Research Center at the University of North Carolina at Chapel Hill, NC, and supported by National Cancer Institute research grant # CA-39279. A preliminary version of this paper was presented at the Annual Meeting of the Society of Behavioral Medicine, Washington, DC, March 1987.

***Unpublished tabulations, 1985 National Health Interview Survey (HIS), provided by the Office on Smoking and Health, US Public Health Service, Rockville, Maryland.

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American Lung Association Report Says EPA and the States Fail Clean Air Test

A new report from the American Lung Association (ALA) says the US Environmental Protection Agency (EPA) has failed to fulfill its mandate to protect the air Americans breathe. According to the report, EPA's "inadequate enforcement of the Clean Air Act" has allowed many states to weaken, delay, or fail to implement important air pollution control measures. Data were analyzed from nine metropolitan areas considered representative of major urban areas with a variety of air pollution problems from an array of sources.

The ALA report found "significant discrepancies" between many states' projections and actual achievements for air pollution reductions, citing as possible reasons: inaccurate computer models; overly optimistic projections of pollution reductions that would result from specific strategies; and deliberate noncompliance with clean air plans. ALA says that EPA has been lax in enforcing state air pollution control commitments, and states took advantage of it. In general, the states complied with the easier, less expensive controls, ALA pointed out, but not the tough measures Congress mandated.

The ALA report recommends that the next Congress authorize a new, stronger version of the Clean Air Act, giving both EPA and the states stricter guidelines and more resources. The report, *Compliance of Selected Areas with Clean Air Act Requirements*, also recommended that new or improved control measures be added to the Clean Air Act, i.e., stronger tailpipe emission standards; tighter national requirements for vehicle inspection and maintenance; and national regulations for area-wide sources such as dry cleaners, gas stations, architectural coatings, and aerosol sprays. For a full copy or executive summary of the report and a chart of the nine cities, contact American Lung Association, 1740 Broadway, New York, NY 10019–4374. Tel: (212) 315–8700.